WSCC Workers' Safety & Compensation Commission

Employer's Repetitive Strain Injury Questionnaire

WSCC Claim Number:

Worker Information

Last Name:	First Name:	
Mailing Address (include postal code):	Community:	Telephone (include area code):
Residential Address:	Date of Birth: YY | MM | DD	Sex: ☐ Male ☐ Female
Employer's Name:	Worker's Occupation:	

Introduction

The WSCC is in receipt of a claim for compensation for a repetitive injury on behalf of your employee. This may be for a progressive condition. This does not involve a direct injury, so we must determine if the injury is work-related or not.

Questions	Responses
1. Briefly describe main functions of this job:	
2. Please describe the workplace set-up, including the position of any furniture, fixed tools, etc., that the worker uses.	
3. Is the workplace hot, cold or normal room temperature?	Hot ☐ Cold ☐ Room Temperature ☐

4. Repetitive tasks in worker's job: *(Specify on grid)*

- **Weight involved with task**
- **Force applied to do task**
- **Right or left hand or both**
- **Hours per day**
- **Continuous hours performed**
- **Frequency/length/number of breaks**
- **Vibratory tools used**

Task	Weight	Force	R/L/ Both	Hrs./ Day	Cont. Hrs.	Breaks	Vibratory Tools
1.							
2.							
3.							
4.							
5.							
6.							
7.							

5. Do any of these movements involve: twisting motion; wringing motion; above shoulder level work; gripping motion?
(Circle and relate to task number above)

Twisting motion ☐	Wringing motion ☐
Above shoulder level work ☐	Gripping motion ☐
Vibrating tools/equipment ☐ (specify): ______	
Dropping small items ☐	Other ☐ (specify): ______

Questions	Responses	
6. Have there been any recent changes in the type or number of tasks the worker performs? If yes, please specify:		
7. Has/had the worker been doing any overtime or extraordinary work? If yes, please specify:		
8. Have there been any changes/ alterations/modifications to the work stations? If yes, when?		
9. How long has the worker had this current job?		
10. When were the symptom(s) first reported to you?		
11. Describe the difficulties the worker was having in performing the job.		
12. Are other workers aware of this worker's problems at work?		
13. Have you made any accommodations for the worker specifically to assist with this problem? *(Hours, workspace, tools, breaks, etc.)* If yes, describe:		
14. Are you aware of any personal activities, including sports, hobbies, recreation, fitness or weight training (past or present) this worker participates in? Type? How often?	**Activity**	**Frequency**
Any additional information?		

This information will help determine if the claim is work-related in whole or in part. The worker is completing a similar form. Include a copy of the worker's job description with this form.

Any information received as a result of the claims process is confidential. Further use or disclosure of the information could result in a fine pursuant to the *Workers' Compensation Acts*.

Signature of Employer: ______________________________ Date: ______________________________

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
www.wscc.nt.ca • www.wscc.nu.ca

Ce formulaire est disponible en français.
ᑖᒃᓇ ᑎᑎᖅᑐᒐᖅ ᐊᑐᐃᓐᓇᐅᓯᒍᖅ ᐃᓄᒃᑎᑐᑦ.